APPENDIX B

SAMPLE INDIVIDUAL PROGRAM AUDIT REPORTS

WORKERS COMPENSATION UTILIZATION REVIEW PLAN AUDIT
(803 KAR 25:190)
Audit no. 1
Date of Audit: June 13, 1997
Location of Audit:
In Attendance:

Marcy Ches, Department of Workers Claims
Dr. Stuart Cook, Department of Workers Claims
XXXXXX Medical Bill Audit
XXXXXX R.N., Employee Health Nurse
XXXXXX R.N., Employee Health Nurse
XXXXXX Corporate Director
XXXXXX Corporate Director

Description of Plan: XXXXX's utilization review plan is unique among approved plans in that it is created by a self-insured, self-administered hospital for the sole use of its employees. The hospital system is part of a larger system. All the other participants are out of state. All workers' compensation is administered entirely in-house. Injured workers see an ER doctor on-site initially upon the occurrence of any injury, but then are free to choose their own physician. The plan covers more than 2,000 employees. An average of 20 injuries occur per month, but most are skin lacerations. Only 1-4 injuries per month are more serious. The human resources department acts as workers' compensation claims adjusters. A workers' compensation committee meets monthly and makes all decisions concerning active workers' compensation cases.

Overall impression:

Upon review XXXXX does not appear to be performing utilization review as envisioned by the Department of Workers Claims, or even as specifically prescribed by the regulation. It is a system of extensive case-management, more similar to managed care, but is not utilization review. However, the objective of utilization review (assuring appropriate treatment) is nevertheless being realized through immediate intervention by the Employee Health Nurses in every case, strong case management, and a heavy emphasis on returning employees to work. Because of the self-insured/self-administered situation, extensive co-ordination occurs between all persons involved in the management of each work-related injury, from the adjuster, to the legal staff, to the nurses and doctors. There is a completely non-adversarial atmosphere because everyone is "on the same team" and getting paid by the same entity. The ongoing and open communication which results in each case between all the persons involved is a factor which lends to the success of this program, even though it is not technically in compliance with the specific requirements of 803 KART 25:190 and 803 KAR 25:096.

Due to the combination of self-administration and a health care setting, the oversight of each injured workers' treatment is very similar to that which occurs in a managed care organization. The

only missing element is an official physician network, but XXXXXX claims they are so knowledgeable about the local physicians which employees generally use, that it is almost like having a network. Many of the physicians that employees frequently use are affiliated with the hospital in some way, such as by having hospital privileges. Therefore, there is the possibility in most cases of a relationship with the treating physician similar to that found in managed care organizations. For their group health care plan, the employees have to use a local provider network developed by XXXXXX. Most continue with those physicians for a work-related injury. Therefore, XXXXX already has a relationship with the physician and the physician is often already familiar with the injured worker.

A workers' compensation committee meets monthly to discuss all active workers' compensation cases. All decisions regarding the overall handling of the cases are made jointly by the committee, which consists of administrative and health care personnel. They call the notes "UR" notes, but upon review the notes are actually more similar to claims adjusting notes. The notes primarily concern legal issues, settlement negotiations, indemnity records, with very little about medical treatment.

The "employee health" nurses, who also act as utilization review nurses, perform very pro-active case-management. They oversee return-to-work and arrange light duty positions at the hospital. They coordinate all the health care for the worker, such as making appointments and following up with the results. The employee health nurses handle work-related and non work-related medical care. In this respect, this arrangement is similar to a 24 hour coverage program. The employees probably do not notice a significant difference in care for work-related vs. non work-related medical care. They deal with the same personnel at the hospital and usually obtain treatment from the same providers. The nurses maintain a health file on each employee which contains both work-related and non work-related information. The XXXXX staff calls the system a "total health care process."

The data base which the regulation requires to be kept recording the instances of review and the outcomes, is simply the nurses case notes which are kept on computer. No statistics could be compiled from it.

The extensive case-management puts the nurse in a position as a advocate for the patient. This reduces the impartiality of the nurse as a utilization reviewer.

XXXXX claims it has not issued any denials or recieved any requests for reconsideration by any physicians. This is alarming, but XXXXX explains that it prefers to put more money into a case on the medical side and on the front end, anticipating that it will result in less indemnity payout, fewer cases filed, less litigation costs. In their opinion, this is just good financial sense. The nurses negotiate with the treating physicians if a procedure seems unwarranted and usually the request is withdrawn. Also, XXXXX claims that due to its familiarity with most local treating physicians, they feel confident that most physicians used by employees consistently provide reasonable and appropriate treatment. Again, this results from the fact that the situation is a self-insured, self-administered, health care setting.

See comments -Causation/Work-relatedness
XXXX Hospital -Clients identity
N/A -Client relations
None -Complaints received at Department of Workers Claims
None -Cost/Savings reports

See comments -Form letter review
N/A -Managed care
See comments -Medical Guidelines
O.K. -Medical Bill Audit
O.K. -Office tour
Did not discuss -Personnel training
See comments -Physician advisors/reviewers
See comments -Pre-Authorization
Did not discuss -Quality controls and assurances
Discussed -Regulations/amendments
See comments -Responsibility for identifying appropriate cases
See comments -Responsibility for designated physicians/form 113
See comments -Responsibility for treatment plans
See comments -Sample files review
See comments -Selection criteria, $3000/30 days
See comments -Time frames for utilization review and medical bill audit
See comments -Written plan review

Specific Comments:

Causation/Work-relatedness. XXXXX claims this is not usually an issue since employees are on-site, the nurses manage the cases from the date of injury, and the nurses maintain the complete health file for each employee.

Form letter review. Form letters for denial and reconsideration were not appropriate.

Medical Guidelines. Could not determine that medical guidelines were being utilized, especially since denials do not occur. The written plan indicates that appropriate guidelines are available for use by utilization review nurses.

Physician advisors/reviewers. An occupational health physician serves as the medical director. He is affiliated with XXXXXX, and is responsible for any first level denials. (There have been none) If reconsideration is requested, the case is sent out to a specialist who is not at XXXXX in order to assure impartiality.

Pre-Authorization. Does not occur as in other plans because employee health nurse is managing the case from the day of injury.

Responsibility for identifying appropriate cases. Does not occur as in other plans because employee health nurse is managing the case from the day of injury. The selection criteria are unnecessary in this situation.

Responsibility for treatment plans. Employee health nurse is in constant communication with treating physicians, so she is obtaining and reviewing treatment plans.

Responsibility for designated physicians. Not using the form 113/designated physician process. However, cases are monitored so closely that the Employee Health Nurses are constantly aware of the designated physician and any referrals.

Sample files review. XXXXX routinely gets an IME, which they call "second opinion", instead of using the utilization review process. There were no cases available for review which had gone through the utilization review denial and appeal process.

Selection criteria, $3000/30 days. Even though medical bill audit flags the $3,000.00 trigger, the employee health/utilization review nurse has already been following the case and reviewing all treatment from the day of the injury. The selection criteria are unnecessary in this situation.

Time frames for utilization review and medical bill audit. Time frames are not relevant for utilization review, since it is not truly occurring and the nurse is proactive in the case. In medical bill audit, time frames seem appropriate.

Written plan review. The written plan approved by the Department of Workers Claims includes all appropriated elements of utilization review. It basically recites the regulations. However, based on discussions with the utilization review staff and the audit of sample files, the process is not being utilized. Specifically, the form 113 is not being used, IME's are being used in lieu of utilization review, and no denials ever occur.

Questions and comments by XXXXX:
1. Can the employer require an injured worker to use sick time for being off for a work injury?
2. If the hospital offers a chicken pox vaccine and an employee refuses and then gets exposed at work, they have to stay home the 10 through the 21 days. Does XXXXX have to pay for the 10 days off? They always have, but since new vaccine is available, they have this question.

Requested Pursuant to Audit:
* I agreed to send a copy of a sample designated physician card. (Sent July 23, 1997)
*Updated denial and reconsideration form letters.

Recommendations:
This situation is so unique that I did not make recommendations to them at this time as to what should be done to get XXXXXX into compliance with the regulations. This program will need addressed separately from the usual vendor utilization review programs we have seen.

WORKERS COMPENSATION UTILIZATION REVIEW PLAN AUDIT
(803 KAR 25:190)

Audit no. 2
Date of Audit: April 16, 1997 & April 29, 1997
Location of Audit: Louisville, Kentucky
In Attendance:

Marcy Ches, Department of Workers Claims
XXXXXX Director
XXXXXX Physician Advisor
XXXXXX R.N.

Description of Plan:
XXXXX has both Managed Care and stand-alone Utilization Review pursuant to 803 KAR 25:190. They are a Utilization Review and Medical Bill Audit Vendor which only handles Kentucky claims. It was created pursuant to Kentucky's managed care statute and regulations. There is an on-sight physician advisor and a nurse manager. The staff handle UR for both the Managed Care and the stand-alone utilization review.

Overall impression: Having the physician advisor on-site is a plus for this program. The staff seem very dedicated and anxious to have a top quality plan, but have struggled for the past year with some personnel and ownership changes. XXXXXX is cooperative in adopting my suggestions for a more comprehensive Utilization Review program. Much of the time spent at the audit consists of education and explanation of the DWC policy, statutory authority, and theory behind the troublesome areas of UR. Generally, the program needs to take a more pro-active role in the UR process, such as dairying a case for later review, reviewing treatment plans, taking a more active role in client education, confirming the designated physician, and identification of selection criteria. Considering the interaction of Medical Bill Audit, Utilization Review, Selection of Physicians, and Treatment Plans, they think that what the Department of Workers Claims wants can be termed "Mini-Managed Care". I offered to come to XXXXXX to meet with representatives of its clients for an educational meeting later this summer. They seemed pleased about the offer. I re-visited on April 29, 1997 to review additional sample files.

Review Checklist:
Discussed -Causation/Work-relatedness
Discussed -Clients identity
See comments -Client relations
See comments -Complaints received at Department of Workers Claims
Requested -Cost/Savings reports
See comments -Form letter review
Discussed -Managed care
O.K. -Medical Guidelines
O.K. -Medical Bill Audit
O.K. -Office tour

O.K.	-Personnel training
O.K.	-Physician advisors/reviewers
See comments	-Pre-Authorization
O.K.	-Quality controls and assurances
Discussed	-Regulations/amendments
See comments	-Responsibility for identifying appropriate cases
See comments	-Responsibility for designated physicians/form 113
See comments	-Responsibility for treatment plans
See comments	-Sample files review
See comments	-Selection criteria, $3000/30 days
O.K.	-Time frames for utilization review and medical bill audit
See comments	-Written plan review

Specific Issues of Concern:

Causation/Work-relatedness. XXXXXX is experiencing the same confusion as most other vendors as to how to handle causation and work-relatedness questions.

Client Relationships. In situations where clients handle their own medical bill audit, there is a breakdown in communication as to whose responsibility it is to identify claims which are appropriate for UR. The Vendor acknowledges that some clients do not send appropriate claims. The Vendor also states that even upon its recommendation to a client that a claim is appropriate for UR, the client often does not give authorization for UR. The Vendor also states that adjusters lack education regarding UR in general. The DWC allows separate approved utilization review and medical bill audit vendors to be used. A separated plan must be filed with the DWC. At XXXXXXX and at others, many clients are reportedly doing there own medical bill audit, but have not indicated such to the Department of Workers Claims. This puts the self-insured or carrier in a position to completely control the instances of UR.

Complaints placed with Department of Workers Claims. The file contained copies of correspondence between XXXXXXX and a former client involving a dispute over fees. The DWC was copied on an ensuing dispute regarding the final fees charged to the client by XXXXXX. I advised them that vendor-client fee arrangements were not within the scope of my oversight of Utilization Review plans. They advised me that the dispute has been resolved.

Form letters and Reports. The same letters were being used for managed care UR and stand-alone UR, which tended to be confusing. Revisions were requested. However, the physician director's medical explanations are thorough and he often cites to specific medical guidelines relied upon for the opinion.

Pre-authorization. The Vendor is confused as to the DWC limited allowance of situations where pre-authorization is available in stand-alone UR, in comparison to the less restrictive pre-authorization in managed care. Like other vendors which have both a MCO and stand-alone UR, this Vendor believes that successful utilization review relies heavily on pre-authorization, especially for certain questionable procedures and types of treatment. Another source of confusion is that even in

instances where pre-authorization is permitted in stand-alone UR, failure to get a pre-authorization is not a basis for non-payment. Another source of confusion is that pre-authorization is not a guaranteed payment as in a general health care setting. UR in the managed care setting is viewed as effective and much less complicated to administer.

Responsibility for designated physicians/form 113. The client is responsible for sending out the form 113 and the issuing the Designated Physician Card to the worker. Although the Vendor asks its client regarding the designated physician, it does not consider it a significant piece of UR. This is because there is no penalty, i.e. not paying a bill, for treatment from a provider other than the designated physician or upon the referral of the designated physician.

Selection criteria, $3000/30 days - Responsibility for identifying appropriate cases. There is confusion as to whose burden it is to identify UR selection criteria, especially $3000 and 30 lost work days. There was also general confusion among UR programs as to what type of report is required upon those criteria being met. A report referred to as the "30 day review" is done regularly when a worker is off 30 days due to the injury. The report is a combination retrospective review of the medical treatment rendered from the beginning of the case and a prospective review of the treatment which would be considered reasonable in the near future. It is not a UR of any specific bill or treatment, but it is used as a guide by the adjuster in determining whether to pay for treatment or not. There is no real follow up on the "30 day review" by the vendor unless the case is referred back by the client. The adjusters do not consider the case as "in UR" where utilization review would be continuous after a selection criteria is met. The adjusters also use the 30 day and $3000 criteria as "whichever is later". The vendor does not identify $3000 in medical bills, but leaves that responsibility to the client, therefore, the vendor reports that it receives very few cases for UR based on that criteria. The vast majority of UR is prospective review based on requests for pre-authorization from providers.

Written plan review. The written plan needs updating to more accurately reflect the processes and policies of the program. See “requested pursuant to audit” section.

Vendor Questions and comments:
1. In 803 KAR 25:096, is the term "resident" intended to describe "pain management", or did the DWC intend that enrollment in a pain management program is subject to pre-certification?
2. There are no guidelines available for pharmaceutical or pain management.

Requested Pursuant to Audit:
-Updated written plan to reflect December 1996 revisions to 803 KAR 25:190.
-Updated client list
-List of self-insured and carriers participating in MCO
-A policy on who will be responsible for identifying selection criteria
-A policy to confirm designated physician
-A policy for additional follow-up on case which have met a selection criteria
-A mechanism whereby the Vendor will identify $3000 in medical bill for clients where the Vendor is providing the MBA, if that is the agreement between client and vendor.

-Any cost/saving analysis which may have been prepared

* A revised plan was received by Office of General Counsel May 23, 1997.

Recommendations: None. This program is operating appropriately, but needs some fine-tuning. Clarification by the Department of Workers Claims on certain issues will be helpful in ending some of the confusion which XXXXXX has experienced.

WORKERS COMPENSATION UTILIZATION REVIEW PLAN AUDIT
(803 KAR 25:190)

Audit no. 3

Date of Audit: June 2, 1997
Location of Audit: Lexington, Kentucky
In Attendance: Marcy Ches
Dr. Stuart Cook
Regional Manager
Supervisor, R.N.

Description of Plan: XXXXXX is a national Managed Care and medical cost containment company which is based in Boston, MA. It operates in 49 states as a managed care and utilization management company. XXXXXX has offices in Atlanta, GA, Tampa, FL, Indianapolis, IN, Waltham, MA, Irving, TX, and St. Peters, MO. The local offices are located in Lexington and Paducah, KY. The medical director is XXXXXXX M.D., Lexington, KY.

Overall impression: XXXXXX appears to be a solid plan in that the personnel managing the utilization review and medical bill audit program have a good understanding of the concepts and the regulatory requirements. However, XXXXXX experiences a problem which is common to many programs which deal with a variety of clients, which is having to rely on the clients to send the appropriate cases for review. Like many programs, XXXXXX also experiences confusion concerning issues such as "What type of report must be generated upon a criteria being met?", "Who is responsible for identifying selection criteria?", and "How should work-relatedness and causation questions be addressed?".

Review Checklist:

See comments -Causation/Work-relatedness
Discussed -Clients identity
See comments -Client relations
None -Complaints received at Department of Workers Claims
None -Cost/Savings reports
See comments -Form letter review
Discussed -Managed care
O.K. -Medical Guidelines
See comments -Medical Bill Audit
None -Office tour
Did not discuss -Personnel training
Discussed -Physician advisors/reviewers
See comments -Pre-Authorization
Did not discuss -Quality controls and assurances
Discussed -Regulations/amendments
See comments -Responsibility for identifying appropriate cases
See comments -Responsibility for designated physicians/form 113

See comments -Responsibility for treatment plans
Discussed -Sample files review
See comments -Selection criteria, $3000/30 days
O.K. -Time frames for utilization review and medical bill audit
O.K. -Written plan review

Specific Comments:

Causation/Work-relatedness. XXXXXX gets some causation questions, and addressing the question is "challenging!". Upon review of the file, an opinion is rendered, but it is not given as a typical utilization review.

Client relations. XXXXXX stated that some clients routinely send claims to XXXXXX where bills have reached $3000. Others rarely send any cases for review. Many adjusters remain confused about when to send a case for review and how to send a case for review.

Complaints received at Department of Workers Claims. None

Fees. Option 1: Pre-authorization approval - $95.00
Pre-authorization denial - $150.00 (physician review included)
Concurrent file review - $45.00-$50.00 (follow-up included)
Specialty review - Varies, but usually $150.00 to $300.00
Option 2: $150.00 flat fee per case for all approved pre-authorizations and concurrent case review. But any physician review is additional $150.00 - $300.00.

Form letter review. Form letters are good. Language explaining XXXXX purpose and indicating that an approval is not a guarantee for payment is helpful and appropriate.

Medical Bill Audit. XXXXXX does fee schedule adjustments (including ground rules), down coding, misused CPT codes. A nurse separates related from non-related charges. When medical bill audit identifies and issue of reasonableness or necessity, the case must be sent to UR. The adjuster often has to act as a coordinator between UR and medical bill audit, especially when XXXXXX is not responsible for both.

Pre-Authorization. XXXXXX makes an effort to get all pertinent medical records prior to making any decision. In managed care, they can deny payment based on a failure to pre-authorize a procedure. In managed care all patients get a managed care card.

Responsibility for treatment plans/designated physicians. For pre-authorization requests, XXXXXX has a place on the request for information regarding the form 113. They have no mechanism to assure that the patient sends the form 113 back, since that is really the carrier's responsibility. Also, they complain that there is no basis for denying payment due to treatment being rendered by a physician other than the designated physician.

Selection criteria, $3000/30 days. If XXXXXX is not performing the medical bill audit for a client, then it must rely on the client to identify cases for $3000 and 30 lost work day review. Where XXXXXX is performing the bill audit, it uses a $2500 flag for utilization review. However, once a case is flagged, the adjuster must be contacted for approval to do UR. The review is not done by XXXXX unless approved by the client. This is typical procedure among plans. Upon a case reaching $3000 "concurrent review" is done. XXXXXX looks at the case with the question of, "Is the treatment appropriate to get the worker recovered and back to work?" A nurse may go out and review the records. The adjuster is provided with a report about the reasonableness of past treatment. It is not a process to approve or deny bills for treatment already rendered, since often the bills have already been paid. It is a retrospective review of a treatment plan. The case is diaried if necessary or if the adjuster requests follow-up. The same type of retrospective review is done for a case triggered by 30 lost work days, but this trigger does not seem to generate many requests for review.

Vendor Questions and Comments:

1. Providers sometimes call for a pre-authorization and expect an answer instantaneously. Or, the provider requests pre-authorization for a surgery, which is scheduled for 6:00 a.m. the next day. It is impossible to get records in these situations. Sometimes it is the carrier's fault for holding the request and not getting it to XXXXXX until the last possible minute.

2. Some providers are offended by having their recommendations questioned or denied by the utilization reviewer.

3. XXXXXX perceives that some adjusters resent the involvement of the utilization review program.

4. Requiring an assurance that a designated physician has been chosen in the bill review section is challenging. The adjusters keep it in the file and do not always send it to XXXXXX. Whether it is in the file or not, the bills still have to be paid in 30 days.

5. XXXXXX believes more pre-authorization in non-managed care UR, such as for specific procedures, would be helpful to the effectiveness of utilization review. UR could take a more proactive role. Retrospective review creates more of an adversarial atmosphere. It is much more difficult to deny payment on reasonableness grounds once the treatment has been rendered.

6. A request for 16 Physical Therapy. XXXXXXapproves 12, denies 4. Is this an approval or denial? It is treated as an approval, but includes appeal rights, nurses name. However, it is not sent to a physician reviewer.

7. A carrier or self-insured wants to do its own UR, however, it wants XXXXXX to do it for them. They want to use XXXXXX's services but issue opinions on their own letterhead. Can this work?

8. If additional information is received by XXXXXX upon an appeal that would change the original reviewing physician's opinion, is it appropriate for the original reviewing physician to reverse himself? (This question has been asked by other physician reviewers and by other UR programs.)
According to the language of the regulation, a ***different*** physician must review the case.

Requested Pursuant to Audit:
*Updated client list
*Expanded appeal rights in denial letter
*Change references to Dept. of Industrial Accidents to Department of Workers Claims (received July 2, 1997)